

Authorization for Release of Information

Section 1: Information About the Use or Disclosure

I authorize the use or disclosure of personal health information about me as described below. I understand that this authorization is voluntary and I may revoke it at any time as described in Section 2.

Member Information

Name _____

I am currently enrolled in the Uniform Medical Plan (UMP) or was enrolled at the time of these services.

UMP I.D. number: W _____ Date of Birth _____

Authorization

☐ I authorize **Washington State Rx Services** to provide the following personal health information about me:

To the following individual(s): _____

Address, City, State and Zip Code: _____

The reason for disclosure/purpose of disclosure is _____.

This authorization will expire two years from the date of my signature or on _____, whichever comes first.

Section 2: Important Information About Your Rights

I have read and understand the following statements about my rights:

- I may cancel this authorization at any time prior to the expiration date or event noted above by telling my provider or UMP in writing. The cancellation will not affect any information either received or given to UMP before the cancellation notice was received.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive health care benefits, such as enrollment, treatment, or payment. If I do not sign this form, UMP may not release my information to any person or organization except those needed to determine my continued coverage, eligibility, and enrollment or as explained in the Notice of Privacy Practices.
- The person or organization that I authorize to receive information about me or my dependent child(ren)* might share it with another person or organization. The information might end up with a person or organization that is not required to protect it the same way UMP is.
- UMP's Notice of Privacy Practices is available upon request by calling UMP Customer Service at 1-888-849-3681 or online at **www.hca.wa.gov/ump**
- This authorization will expire two years from the date below, unless otherwise noted above in the authorization section.

Section 3: Signature

Signature of member or member's representative

Date

Form must be completed before signing.

Printed name of member's representative

Relationship to member

Please attach legal documentation if you are the guardian, custodian, holder of power of attorney or other representative of the member.

Please submit the requested information to:

**Washington State Rx Services
Attn: Privacy Office
PO Box 40168
Portland, OR 97240-0168**

Or fax to: (503) 412-4068 (a secure fax line) at your earliest convenience.